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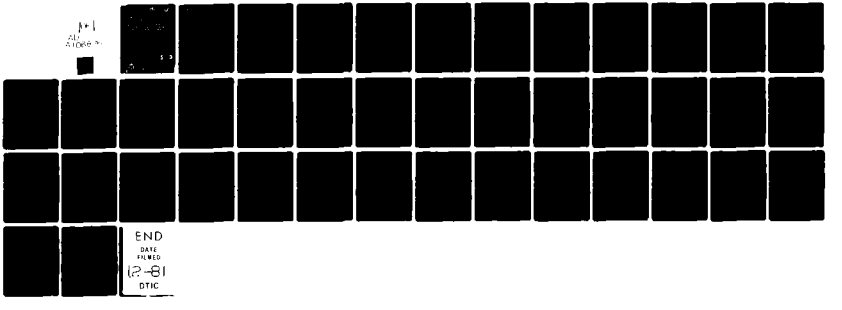

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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable Russell B. Long United States Senate

(6) # Medicare's Reimbursement Policies for Durable Medical Equipment Should Be Modified And Made More Consistent.

Medicare payments for durable medical equipment--hospital beds, wheelchairs, commodes, etc.--were estimated at $125 million for 1979. For two items of equipment (standard hospital beds and wheelchairs), payments for rentals or purchases may not exceed the lowest charge level at which these items are widely and consistently available in a locality.

Because the standard items cannot be bought at the amounts allowed and are being purchased in small quantities, the present method of computing the lowest charge levels should be discontinued for purchases.

Different and more restrictive durable medical equipment reimbursement and coverage screens are being imposed by the Government in the Atlanta region. Although the screens do help identify claims for unnecessary items, beneficiaries in the Atlanta region must meet criteria that beneficiaries in other parts of the country do not have to meet. In a national program, such as Medicare, the imposition of local requirements by the administrative agency does not seem appropriate.

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(14) GAO/HRD-81-147 SEPTEMBER 10, 1981

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-204567

The Honorable Russell B. Long
United States Senate

Dear Senator Long:

Because of complaints from suppliers of durable medical equipment to Medicare beneficiaries in some southeastern States that they were not being treated fairly by the Health Care Financing Administration's (HCFA's) Atlanta Regional Office and the Medicare carriers in that region, in February 1980 the former Chairman of the Subcommittee on Health of the Senate Committee on Finance asked us to look into selected Medicare reimbursement practices in Georgia, Alabama, Florida, and South Carolina in comparison with other States. The other States visited were New Hampshire, Vermont, Connecticut, Missouri, and northern California. Although the former Chairman did not return to the Senate in January 1981, there was still considerable interest in the issues raised and the Subcommittee staff suggested that we complete our work and submit our report to you.

As requested by your office, we did not obtain formal comments from the Department of Health and Human Services on this report; however, our findings and a draft of this report were discussed with HCFA officials on several occasions. As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 14 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
RUSSELL B. LONG
UNITED STATES SENATE

MEDICARE'S REIMBURSEMENT POLICIES FOR DURABLE MEDICAL EQUIPMENT SHOULD BE MODIFIED AND MADE MORE CONSISTENT

D I G E S T

This review was requested by the former Chairman of the Subcommittee on Health, Senate Committee on Finance, to evaluate allegations to the effect that suppliers of durable medical equipment to Medicare beneficiaries in certain southeastern States were being subjected to discriminatory reimbursement and coverage requirements.

Medicare payments for durable medical equipment--hospital beds, wheelchairs, commodes, and oxygen equipment--are estimated in excess of $125 million a year. Durable medical equipment for use in a beneficiary's home is covered under Medicare if it is medically necessary. Medicare payments for such items are made by contract paying agents called carriers.

For two items of equipment (standard hospital beds and wheelchairs), the payments may not exceed an amount based on the lowest charge level at which the items are "widely and consistently available in a locality." The Health Care Financing Administration (HCFA) has defined the lowest charge level as one high enough to include the cumulative 25th percentile in the distribution of actual charges submitted during a previous period.

GAO was asked to review the payment levels for durable medical equipment in Georgia, Alabama, Florida, South Carolina, and selected other States. The other States were Connecticut, New Hampshire, Vermont, Missouri, and northern California.

Specifically, GAO was asked to determine

--whether standard hospital beds and wheelchairs are widely and consistently available to beneficiaries at the 25th percentile

--whether suppliers in the HCFA Atlanta region were subject to different and more restrictive coverage and reimbursement criteria than were being applied to suppliers in other areas, and

--the appropriateness of other payment practices and policies followed by carriers in the Atlanta region.

AVAILABILITY OF STANDARD WHEELCHAIRS AND HOSPITAL BEDS AT THE LOWEST CHARGE LEVEL

There were large geographical areas in most of the States reviewed containing thousands of Medicare beneficiaries where standard wheelchairs and hospital beds were not available at the lowest charge level.

This condition was less critical for rentals than for purchases because more suppliers took assignment for rentals than for purchases. When a supplier takes assignment, it agrees to accept the Medicare allowance as the full charge. Medicare pays the supplier 80 percent of the allowance, and the beneficiary is liable for the balance. If a supplier does not take assignment, Medicare pays the beneficiary 80 percent of the allowed charge, and the beneficiary is liable for the (1) remaining 20 percent of the allowed charge and (2) entire difference between the actual charge and the allowed charge.

Because carriers do not accumulate data on the number or rate of assignments for these items, HCFA does not know what the assignment rates are or their precise impact on availability. However, the limited data GAO developed indicate that the assignment rates are significantly higher for rentals than for purchases, and thus, rental items were probably available to beneficiaries if they knew where to shop. However, beneficiaries or their doctors have not been told by the regional offices or the carriers about where wheelchairs and hospital beds are available at or below the 25th percentile or which suppliers usually accept assignment and thus accept what Medicare allows.

The unavailability of these items for purchase at the lowest charge level tends to defeat the purpose of section 16 of Public Law 95-142. This provision requires reimbursement based on the purchase of durable medical equipment if less costly than long-term rentals. However, because many suppliers do not accept assignments on purchases, beneficiaries who are reimbursed on the

basis of a purchase are disadvantaged because they would be paying larger portions of the bill. GAO identified other problems in administering the lowest charge provision. Carriers servicing New Hampshire, Vermont, Connecticut, Alabama, Missouri, and northern California were not always able to establish a lowest charge for purchases due to the insufficient number of transactions and related charge data. Carriers in Missouri and South Carolina set the lowest charge level for rentals below the 25th percentile due to erroneous data (see p. 14) or because the 25th percentile was not considered "inherently reasonable" (see p. 25).

GAO believes HCFA should

--discontinue applying the 25th percentile lowest charge level for purchases because (1) there are not enough data to compute it, (2) equipment is not widely and consistently available at the computed price, and (3) the limit tends to defeat the purpose of Public Law 95-142;

--require carriers to compute data on assignments for items reimbursed at the lowest charge level to monitor the availability of such items; and

--inform beneficiaries or their doctors where items can be acquired at or below the allowed amounts or about suppliers who usually take assignments. (See p. 16.)

COVERAGE AND REIMBURSEMENT POLICIES INCONSISTENT AMONG REGIONS AND MEDICARE CARRIERS

The coverage and utilization screens used by HCFA-Atlanta differ from those used in the Boston, San Francisco, and Kansas City regions. Beneficiaries and suppliers in the Atlanta region, for example, must meet certain criteria that beneficiaries and suppliers in other parts of the country do not have to meet. Even within the Atlanta region carriers have differing requirements.

Carriers in Georgia, Alabama, South Carolina, and most of Florida use screens to (1) limit oxygen payments to the least costly delivery method, (2) identify and deny payments for oxygen equipment

for beneficiaries who need oxygen only on a standby basis, (3) test a beneficiary's medical need for oxygen, (4) test a beneficiary's medical need for intermittent positive pressure breathing machines, and (5) identify equipment combinations that have mutually exclusive requirements. Only one of the five carriers reviewed outside of the Atlanta region used any of these screens. This carrier, Connecticut General, used both a screen to identify standby oxygen usage and a test to determine a beneficiary's need for oxygen.

Carriers in the Atlanta region were also the only carriers reviewed that used inherent reasonableness tests to assess the validity of durable medical equipment allowances. These carriers compared price increases from one period to the next and, if the percent increase was judged too high, adjusted the allowance. These adjustments appeared subjective and were made without any formal guidelines or criteria. While such factors as screens and inherent reasonableness may be needed to control unnecessary costs, some carriers and suppliers questioned how much they actually saved and the inconsistencies with which they were implemented. Cost reductions resulting from the use of screens and inherent reasonableness tests are difficult to measure.

Although variations among carriers in reimbursement, coverage, and medical policy matters are not unusual, GAO believes that HCFA should insure that Medicare reimbursement policies and coverage and utilization screens imposed by the agency are consistently applied in all regions. Also, HCFA should determine, to the extent practicable, the cost effectiveness of coverage and utilization screens before or during their implementation. (See p. 27.)

OTHER ISSUES IN THE ATLANTA REGION

Carriers in the Atlanta region have improved their process for informing suppliers of policy changes. Carriers now give suppliers from 30 to 45 days notice of any changes. Suppliers complained that before these improvements, there had been cases where they became aware of new policies only after claims had been denied for not complying with such policies.

Carriers in the Atlanta region were also directed to conduct postpayment audits on suppliers who billed for mileage on deliveries. With Medicare rules allowing carriers up to 4 years to review paid claims, suppliers' previously approved claims for deliveries were reviewed. Results of these audits in South Carolina and Georgia showed that suppliers had overcharged the Medicare program by about $112,000. Specifically, the carriers determined that some suppliers were billing for multiple round trips to deliver equipment to beneficiaries in a locality even though only one round trip was made. The procedures used to conduct the delivery charge audits appear to be appropriate.

Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IPPB	intermittent positive pressure breathing

GLOSSARY

Assigned Medicare claim	the medical provider agrees to accept the payment amount set by Medicare as full reimbursement
Assignment/nonassignment rate	the percentage of total claims that are either assigned or nonassigned
Blood gas study	a laboratory analysis that measures the parts of oxygen in a person's blood
Concentrator	a machine which manufactures oxygen-enriched air
Lowest charge level	a maximum Medicare reimbursement rate established by carriers for items which are considered widely and consistently available
Nonassigned Medicare claim	the medical provider does not agree to accept the payment amount set by Medicare as full reimbursement; the provider bills the beneficiary for its total charge and the beneficiary is liable for the difference between the billed amount and what Medicare allows as its reasonable charge
Postpayment audit	selected reviews of paid claims by carriers
Pulmonary function test	a laboratory analysis that measures a person's vital lung capacity
Screen	a general term used to describe various criteria and tests used by carriers for determining Medicare coverage and reimbursement rates
Standby oxygen	oxygen used on a precautionary noncontinuous basis
Tests for inherent reasonableness	various analyses performed by carriers to determine the reasonableness of charges submitted by providers

CHAPTER 1

INTRODUCTION

The former Chairman of the Subcommittee on Health of the Senate Committee on Finance requested that we review selected aspects of the Medicare program's payment practices for durable medical equipment in Georgia, Alabama, Florida, and South Carolina. This report covers the following issues raised by the Chairman:

--Whether hospital beds and wheelchairs were "widely and consistently" available at the 25th percentile of previous charges.

--Whether different coverage and reimbursement criteria were being applied to suppliers in Georgia, Alabama, Florida, and South Carolina than were being applied to dealers located in other States.

--The adequacy of postpayment review procedures, particularly for delivery charges.

--The adequacy of the procedures for keeping medical equipment dealers informed of policy changes.

THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395) (Medicare) was enacted on July 30, 1965, as the Social Security Amendments of 1965. Medicare, which became effective July 1, 1966, is a Government program which pays much of the health care costs for eligible persons age 65 or older. The program is administered by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS).

Medicare consists of two parts. Part A (Hospital Insurance for the Aged and Disabled) covers inpatient hospital care and, after a hospital stay, inpatient care in a skilled nursing facility or a patient's home. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. As of July 1, 1980, about 27.5 million people were enrolled for Part A benefits. Benefit payments for fiscal year 1980 amounted to $23.8 billion.

Part B (Supplementary Medical Insurance for the Aged and Disabled) covers (1) physician services, (2) outpatient hospital care, (3) home health care, and (4) other medical and health services. This insurance generally covers 80 percent of the reasonable charges or costs for these services and/or supplies subject to an annual $60 deductible. Enrollment in Part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and appropriations from the general revenues of the U.S. Treasury. As of

July 1, 1980, about 27.1 million people were enrolled for Part B benefits. Benefit payments in fiscal year 1980 for Part B amounted to $10.1 billion.

HCFA administers Part A benefits furnished by institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) with assistance from 70 intermediaries. These intermediaries pay health service providers usually on the basis of reasonable costs. Sixty-one local Blue Cross organizations subcontract under the Blue Cross Association, which has a national prime contract. Eight commercial insurance companies and HCFA's Division of Direct Reimbursement are the remaining intermediaries.

HCFA also administers Part B benefits furnished by such non-institutional providers as doctors, laboratories, and suppliers with the assistance of carriers under prime contracts with the Government. Carriers perform many functions similar to intermediaries; however, their payments are usually on the basis of reasonable charges. Presently, 29 of the carriers are Blue Shield plans, 13 are commercial insurance companies, 1 is principally a data processing firm, and 1 is a State agency. Durable medical equipment and oxygen are primarily Part B claims and are paid by the carriers. HCFA estimates that payments for durable medical equipment and oxygen are in excess of $125 million per year.

DURABLE MEDICAL EQUIPMENT

HCFA instructions define durable medical equipment as equipment which

--can withstand repeated use,

--is primarily and customarily medical in nature, and

--is generally not useful to a person who does not have an illness or injury.

Under HHS regulations, to be covered by Medicare the equipment must be used in the patient's home and be considered medically necessary and reasonable for the treatment of the patient's illness or injury. Such items as hospital beds, wheelchairs, respirators, medical regulators, crutches, commodes, and traction equipment are considered to be durable medical equipment.

Legislative background on coverage of durable medical equipment under Part B of Medicare

Under the Social Security Amendments of 1965 (79 Stat. 286), which established Medicare, Part B covered only the rental of durable medical equipment. The Social Security Amendments of 1967 (81 Stat. 821), approved January 1968, provided for reimbursement

for either purchase or rental of durable medical equipment. If a beneficiary elected to purchase equipment after December 31, 1967, reimbursement, subject to the deductible and coinsurance provisions, could be made under Part B of Medicare

--on a lump-sum basis for equipment costing $50 or less or

--in periodic installments equal to the rental payments for equipment costing over $50.

To control and contain costs for durable medical equipment, the Social Security Amendments of 1972 (Public Law 92-603) modified the payment provisions for specific equipment items. For medical services, supplies, and equipment (and equipment servicing) that in the judgment of the Secretary of HHS do not vary significantly in quality from one supplier to another, reimbursement may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality.

The 1972 amendments also authorized HHS to experiment with reimbursement approaches to avoid the unreasonable expenses to the program resulting from prolonged rentals of durable medical equipment and to implement without further legislation any purchase approach found to be workable, desirable, and economical.

Section 16 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977, further revised the reimbursement provisions. The legislation was intended to protect the Medicare program and beneficiaries against excessive expenditures caused by prolonged rentals of equipment. The legislation authorized the Secretary of HHS to (1) determine whether purchase would cost less or be more practical than rental and if so reimburse on a purchase basis; (2) require purchase on a lease-purchase or other basis and make payment based on any applicable lease-purchase agreement, or in a lump sum if purchase is determined to be less costly or more practical; (3) enter into agreements with suppliers of durable medical equipment that establish equitable, economical, and feasible reimbursement procedures; (4) encourage lease-purchase arrangements; and (5) offer an incentive to purchase used equipment.

Although this provision became effective for equipment purchased or rented on or after October 1, 1977, HCFA did not issue final implementing regulations until July 1, 1980, which became effective December 29, 1980--3 years and 3 months after the effective date of the law. Further, as of July 1981, HCFA and its carriers had not implemented the regulations because of a lack of implementing guidelines.

LOWEST CHARGE LEVEL--25TH PERCENTILE

HCFA issued regulations to implement the lowest charge level provision in July 1978 and final regulations in December 1978. A Part B Intermediary Letter (IL 79-1) was issued by HCFA in January 1979 and instructed Part B carriers how to implement the provision. HCFA instructed the carriers to apply the requirement initially to two items of durable medical equipment--standard wheelchairs and hospital beds. HCFA instructed carriers to begin applying the lowest reasonable charge requirement no later than when first beginning to process claims received on or after January 1, 1979.

Lowest charge level methodology

HCFA defines the lowest charge as one high enough to include the cumulative 25th percentile in the distribution of actual charges submitted for a particular item or service in a locality.

For example, all of the valid charges in a locality for the July through September 1978 period for a standard wheelchair rental would be arrayed in ascending order as in the following table.

Actual Monthly Charges In A Locality
For Standard Wheelchair Rental

July to September 1978	Number of charges
$18.00	70
18.25	40
18.50	90
18.75	40
19.00	60
19.50	30
Total	330

In this example, the 83rd charge (one of the charges made at $18.25) is high enough to include the prices charged for a standard wheelchair rental in at least one of every four transactions involving that service during the July and September 1978 period. Therefore, in this example, the lowest charge level for a standard wheelchair rental would be $18.25.

HCFA requires that the Part B carriers calculate the lowest charge level for standard hospital beds and wheelchairs semi-annually for use in processing claims received on or after July 1 and January 1 of each year. For claims processed from July 1 through December 31, the lowest charge level is based on charge data derived from claims processed during the preceding January through March.

The Intermediary Letter allowed carriers (with HCFA approval) to modify their existing prevailing charge localities when 1/ applying the lowest charge level. The letter stated that it was reasonable for a prudent purchaser to obtain an item from beyond the boundaries of a prevailing charge locality if he or she can do so without being substantially inconvenienced. It also stated that a prevailing charge locality might be too small to yield sufficient prior charge data for an item to permit a valid lowest charge level calculation. HCFA indicated that in such a case it would normally expect a carrier to designate its entire service area or geographic areas larger than the prevailing charge locality or localities for calculating the lowest charge level for a particular item.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to obtain information and evaluate the impact of the four issues raised by the request. We did work at four HCFA regional offices and nine Part B carriers. The carriers and their respective service areas are shown in the following table.

Carrier	Service area
1. New Hampshire/Vermont Medical Service	New Hampshire and Vermont
2. Connecticut General Life Insurance Company	Connecticut
3. General American Life Insurance Company	Eastern and southern Missouri
4. Kansas City Blue Shield	Remainder of Missouri and two counties in Kansas
5. Prudential Insurance Company of America	Georgia
6. Alabama Blue Shield	Alabama
7. Florida Blue Shield	Florida, except Dade and Monroe Counties
8. South Carolina Blue Shield	South Carolina
9. California Blue Shield	Northern California

1/These are geographical areas, such as one or more counties for which the Medicare upper limits for allowable doctors' charges are calculated.

The States in the Atlanta region were selected based on the Subcommittee's request. The States outside the Atlanta region were selected based on the availability of our staff and desire to obtain coverage for at least three of the other nine HCFA regional offices. The four issues and our methodology for addressing them follows:

1. To assess whether durable medical equipment being reimbursed at the 25th percentile is widely and consistently available at that payment level, we obtained supplier charge data for standard wheelchairs and hospital beds from the nine carriers. The charge data reviewed were from suppliers whose charges were at or below and above the lowest charge level for the equipment items based on three charge data periods (July-Sept. 1978, Jan.-Mar. 1979, and July-Sept. 1979). At seven carriers, we reviewed all three charge data periods. At the other two carriers, we reviewed the latter two charge data periods. 1/

The availability of the standard items at the lowest charge level was determined for each period reviewed at each carrier. We plotted on maps for each of the two or three periods, the locations of the suppliers which billed at or below the lowest charge level and drew conclusions as to their availability to beneficiaries.

For the January 1980 update, we also estimated the number of Medicare beneficiaries not located within a 20-mile radius of a supplier billing at or below the lowest charge level. Using maps, we plotted suppliers billing at or below the lowest charge level as established in January 1980. A radius of 20 miles was drawn around each supplier. Using Medicare population statistics by county as of July 1, 1977, we estimated the number of Medicare beneficiaries not residing within 20 miles of a supplier that had submitted charges at or below the 25th percentile.

2. To determine whether the coverage and reimbursement criteria applied to equipment dealers in the Atlanta region were different from those applied in other regions, we selected several coverage and reimbursement items and determined how they were implemented. After assessing what policies carriers were following, we compared the results and drew conclusions as to whether the dealers and beneficiaries in the Atlanta region were being treated differently. We also examined claims for randomly selected beneficiaries outside the Atlanta region to see whether a utilization screen applied in the Atlanta region might have identified unnecessary costs elsewhere.

1/For Florida the charge data for the two periods were combined and thus were not comparable to the data obtained from the other carriers.

3. To assess the adequacy of HCFA-Atlanta's postpayment review procedures, particularly for delivery charges, we reviewed the procedures followed by the carriers and discussed their application with HCFA personnel.

4. To assess the adequacy of HCFA-Atlanta's procedures for keeping medical equipment dealers informed of policy changes, we contacted suppliers in the Atlanta region and obtained their opinions regarding the reasonableness of HCFA's procedures. We also discussed with HCFA and carrier personnel the appropriateness of their policies for communicating with suppliers.

CHAPTER 2

AVAILABILITY OF STANDARD WHEELCHAIRS AND HOSPITAL BEDS AT THE LOWEST CHARGE LEVEL

There were large geographical areas in the States reviewed (except Connecticut) where thousands of Medicare beneficiaries lived where standard wheelchairs and hospital beds were not available at the amounts Medicare allows. This was because of the concentration in the same locality of suppliers billing at or below the 25th percentile. While this condition was alleviated regarding rentals where the suppliers usually took assignment, and therefore agreed to accept the Medicare allowance as the full charge, suppliers usually did not accept assignment on purchases.

The implementation of section 16 of Public Law 95-142 requires purchases if less costly than long-term rentals of durable medical equipment. Therefore, the absence of suppliers who are willing to accept assignment on purchases, but do accept assignment on rentals at the lowest charge level would have the effect of defeating the purpose of Public Law 95-142 by placing a hardship on beneficiaries who purchase because they would be paying a larger portion of the bills.

Section 1842(b)(3) of the Medicare law provides that medical equipment, that in the opinion of the Secretary of HHS does not generally vary significantly in quality from one supplier to another, may not exceed the lowest charge level at which such equipment is widely and consistently available in a locality. HCFA initially applied this provision to two items of durable medical equipment: standard wheelchairs and hospital beds. HCFA instructed the carriers to set the lowest charge level for these items at a level which includes the cumulative 25th percentile in the distribution of actual submitted charges. HCFA instructions state that these items will be considered widely and consistently available at the 25th percentile. No studies were made to determine whether standard wheelchairs and hospital beds were generally available at that price level. A HCFA official stated that the 25th percentile was HCFA's "best guess."

Carriers have had problems with the lowest charge level since the first quarter of 1979 when most carriers began applying it. Carriers have calculated and applied the provision differently. In addition, most carriers we contacted did not have enough data with which to calculate 25th percentiles for some standard equipment purchases. Also, beneficiaries or their doctors have not been routinely informed by the carriers or HCFA concerning where standard equipment items were available at or below the 25th percentile.

These problems point towards the need for HCFA to (1) discontinue applying the 25th percentile on purchases, (2) require carriers to accumulate data on assignments of standard items to monitor the availability of such items, and (3) inform beneficiaries or their doctors of where standard items can be acquired at or below the allowed amount or those suppliers that usually accept assignments and thus accept what Medicare allows.

AVAILABILITY OF STANDARD WHEELCHAIRS AND HOSPITAL BEDS AT THE 25TH PERCENTILE

We analyzed charge data to determine the availability of standard wheelchairs and hospital beds for three periods--the initial lowest charge screen period and the July 1979 and January 1980 screen updates--in five States and portions of two other States and for the July 1979 and January 1980 periods only in two States. 1/

Using maps, we plotted the location of suppliers submitting charges at or below the 25th percentile for standard equipment items for several screen base data periods. Results indicated that in all periods reviewed there were large geographical areas in most States where standard wheelchairs and hospital beds were not available at the amounts allowed by Medicare.

Thousands of Medicare beneficiaries lived at least 20 miles away from suppliers billing at or below the lowest charge level. To illustrate this point, we calculated the number of Medicare beneficiaries who lived an estimated more than 20 miles from suppliers billing at or below the 25th percentile established in January 1980. This is presented in the table on the following page.

The number of beneficiaries not located within 20 miles of a supplier billing at or below the lowest charge level is immaterial from the beneficiaries' perspective if other suppliers billing at a higher rate take assignment. These suppliers agree to accept the Medicare allowance as the full charge. However, while it is known more suppliers take assignment on rentals than purchases, the exact percentages were not known.

1/New Hampshire, Vermont, Connecticut, Missouri, South Carolina, and northern California were analyzed for three periods. Georgia and Alabama were analyzed for two periods.

Beneficiaries Not Located Within 20 Miles of Suppliers Billing At or Below the 25th Percentile Established in January 1980 (note a)

State	Total beneficiaries	Rentals				Purchases			
		Wheelchairs		Hospital beds		Wheelchairs		Hospital beds	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
	(thousands)								
Alabama	439	108	25	117	27	165	38	(b)	(b)
California	999	238	24	237	24	297	30	689	69
Connecticut	357	0	0	22	6	26	7	(b)	(b)
Florida	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)
Georgia	514	285	55	100	19	495	96	363	74
Missouri	657	312	48	245	37	289	44	(b)	(b)
New Hampshire	100	13	13	16	16	46	46	70	70
South Carolina	282	151	54	133	47	204	72	224	79
Vermont	60	24	40	33	55	40	67	52	87
Total	3,408	1,131	33	903	27	1,562	46	d/1,398	71

a/Based on the number of Medicare beneficiaries as of July 1, 1977.

b/No 25th percentile was calculated.

c/Population analysis not available.

d/Computed excluding Alabama, Connecticut, and Missouri.

EFFECT OF ASSIGNMENTS ON AVAILABILITY OF STANDARD EQUIPMENT ITEMS AT THE LOWEST CHARGE LEVEL

HCFA does not know what the assignment rate is for durable medical equipment claims because carriers do not maintain this information by type of claim. Although HCFA has asked carriers to provide these data as part of its study of the lowest charge level, it may not receive very much. We reviewed responses from eight carriers included in our review of which only two provided data on durable medical equipment assignment rates. Kansas City Blue Shield and General American Life Insurance Company provided information on assignment rates for standard wheelchairs and hospital beds for September 1979.

Kansas City Blue Shield reported an assignment rate of 74.3 and 0 percent, respectively, for rental and purchase claims. General American reported an assignment rate of 40.3 and 6.8 percent, respectively, for rental and purchase claims. Both carrier responses indicated assignment rates have dropped since the lowest charge level provision was implemented.

HCFA-Atlanta estimated for its nine carriers that the assignment rate for durable medical equipment rental claims was over 90 percent. This estimate, however, was based on a very limited survey. No estimate was made for purchase claims. We did analyze assignment rates for standard wheelchairs and hospital bed claims processed during 1979 in New Hampshire, Vermont, and Connecticut. As shown below, our analysis showed that the assignment rate was significantly higher for rentals of standard items than for purchases.

1979 Assigned and Nonassigned Claims for Standard Items in New Hampshire, Vermont, and Connecticut

Items	Assigned		Nonassigned	
	Number	Percent	Number	Percent
Rental:				
Standard wheelchair	4,984	82	1,096	18
Hospital bed	3,939	82	875	18
Total	8,923	82	1,971	18
Purchase:				
Standard wheelchair	155	31	341	69
Hospital bed	29	41	42	59
Total	184	32	383	68

Overall about 18 percent of the rental claims and 68 percent of the purchase claims for standard wheelchairs and hospital beds were nonassigned in New Hampshire, Vermont, and Connecticut during 1979.

Also, we contacted 147 suppliers in eight States to determine their policies with respect to accepting Medicare assignments for rentals and purchases. As shown in the following table, except for suppliers in northern California, most suppliers responded that they did accept assignment on rentals but not on purchases.

Supplier Responses on
Assignment Rate Policies

State	Suppliers contacted	Suppliers taking assignment			
		Rentals		Purchase	
		Number	Percent	Number	Percent
Missouri	36	21	58	5	14
New Hampshire	15	11	73	8	53
Vermont	8	6	75	2	25
Connecticut	42	30	71	13	31
Alabama	6	5	83	0	0
Georgia	10	7	70	4	40
Florida	10	7	70	2	20
Northern California	20	5	25	2	10
Total	147	92	63	36	24

The assignment rate does affect the availability of standard items to beneficiaries at the lowest charge levels. For most of the areas reviewed, the information obtained suggests that the assignment rates for rentals is probably high enough to assure availability of standard items--irrespective of what Medicare allows--if beneficiaries know where to shop. However, until HCFA requires its carriers to separately accumulate assignment rate data for items subject to the lowest charge reimbursement rate, the impact on availability cannot be accurately determined. On the basis of such data, HCFA should also determine what constitutes an acceptable assignment rate as it applies to the definition of "widely and consistently available" at the lowest charge level.

In our view, the accumulation of assignment data would also provide HCFA with an indication of the reasonableness of the lowest charge allowances because one fair test of the reasonableness of a price in a competitive market is what a seller is willing to accept as opposed to what a supplier charges.

PROBLEMS IN DEVELOPING AND APPLYING THE LOWEST CHARGE LEVEL

There were problems in developing, applying, and monitoring the lowest charge level provision. Five of the nine carriers visited were unable to establish 25th percentiles for the purchase of some standard equipment items due to insufficient charge data. Furthermore, during the screen periods reviewed, some carriers used incorrect data in 25th percentile calculations and some set the level below the 25th percentile in error.

Insufficient data used

Five carriers in six States did not have enough charge data to calculate 25th percentiles for standard equipment purchases. Under HCFA's instruction, at least four charges are needed for a previous 3-month period to calculate a "lowest charge." In all areas reviewed, considerably more supplier charge data were available for calculating 25th percentiles for standard equipment rentals than for purchases. Carriers servicing Alabama, New Hampshire, Vermont, Connecticut, northern California, and Missouri had problems calculating 25th percentiles for standard equipment purchases due to insufficient charge data.

--For the January 1980 screen period, Blue Cross/Blue Shield of Alabama had insufficient data to establish a new 25th percentile for standard hospital bed purchases. The carrier also recommended to HCFA that it retain its current allowance for standard wheelchair purchases due to insufficient data during this period.

--For the initial screen period and the January 1980 screen update, Blue Shield of Kansas City could not establish a 25th percentile for standard hospital bed purchases. The carrier had only one charge available for the initial screen period and two for the January 1980 update with which to calculate the 25th percentiles.

--The Connecticut carrier had insufficient charge data to calculate 25th percentiles for standard hospital bed purchases in all three periods and for standard wheelchair purchases in one of its four screen areas during the initial screen period.

--The New Hampshire/Vermont carrier could not calculate 25th percentiles in both States for purchases of either standard wheelchairs or standard beds during the initial screen period or for hospital bed purchases in Vermont for the January 1980 update.

Carriers used several methods to establish a lowest charge level when they did not have sufficient charge data. The Alabama carrier recommended using the 25th percentile established during the prior screen period. The New Hampshire/Vermont carrier paid purchase claims during the initial screen period based on price lists and other available price data. For the January 1980 screen update, the carrier--with HCFA approval--combined New Hampshire and Vermont screen data to calculate a 25th percentile for standard hospital bed purchases in Vermont. The resulting 25th percentile was based on 10 purchases applicable to 6 suppliers in both States.

There have not been many purchases of standard wheelchairs and hospital beds. As a result carriers have had consistent problems calculating 25th percentiles for standard equipment purchases because of insufficient charge data. We believe that HCFA should reconsider applying the lowest charge levels to purchases of these items.

Incorrect data used

Two carriers (General American and Kansas City Blue Shield) used some incorrect data in computing the 25th percentile, and General American set lowest charge levels below the 25th percentile in error. Alabama Blue Shield applied the 25th percentile to nonstandard items in error which resulted in significant underpayments.

The two carriers servicing Missouri and two counties in Kansas included charges for nonstandard items in their calculations. Kansas City Blue Shield assumed charges for wheelchairs that were two to three times higher than the 25th percentile were for standard wheelchairs, but they were not. During the January 1980 screen update, General American had several errors in its 25th percentile calculation for one locality which resulted in a higher than correct rate for standard wheelchair rentals.

During the July 1979 screen update, the same carrier established a 20th percentile index for three of its localities until it was discovered and corrected during October 1979. During the period the index was used, the carrier underpaid 26 beneficiaries from $10.25 to $15.56 per claim. The carrier--with HCFA approval--repaid these beneficiaries.

The carrier servicing Alabama incorrectly applied the 25th percentile to three types of nonstandard wheelchairs during the initial screen period and the July 1979 and January 1980 updates. This carrier discovered the error when HCFA requested it to review the computation after numerous complaints from a supplier. The supplier first complained in January 1980. In a November 3, 1980, memorandum to HCFA-Atlanta, the carrier estimated that for the period (Feb. 1, 1979, to June 30, 1980), the error resulted in about $622 in overpayments and about $5,077 in underpayments to both suppliers and beneficiaries. In November 14 and December 3, 1980, memorandums, HCFA-Atlanta instructed the carrier to adjust all assigned and nonassigned claims, respectively, to the correct payment levels.

BENEFICIARIES WERE NOT TOLD WHERE TO BUY STANDARD EQUIPMENT AT OR BELOW THE LOWEST CHARGE LEVEL

The regulations implied but did not require that HCFA would instruct carriers to inform beneficiaries about where standard

equipment items were available at or below the 25th percentile. None of the four HCFA regional offices visited had either advised carriers to routinely provide the information or advised beneficiaries about where standard items could be obtained at these prices. The regional officials agreed that beneficiaries have difficulty shopping effectively for lowest available prices on durable medical equipment.

Most carriers contacted had developed lists of suppliers billing at or below the 25th percentile, but had not directly informed beneficiaries about the lists. Carriers did make the lists available to the public upon request. A HCFA-Atlanta regional official stated that, if HCFA instructed carriers to publish the lists, it could be criticized by suppliers billing above the 25th percentile for attempting to restrict their business. He said that consequently HCFA relies on the beneficiaries or their doctors to find the best prices to meet their needs.

Based on contacts with beneficiaries and HCFA officials during the review, such reliance appears unrealistic. Many of the beneficiaries contacted did not make arrangements to acquire the equipment they needed. A physician, or some other agent acting for the beneficiary arranged for their equipment needs.

HCFA officials in the San Francisco region told us that they believed informing beneficiaries about where standard durable medical equipment items were available at or below the 25th percentile would be unproductive. They stated that generally beneficiaries are unable to shop around because of their low income, limited education, inability to travel for medical reasons, and lack of transportation. If the view of these officials is correct, then HCFA's application of the prudent purchaser concept and assumption that beneficiaries can be expected to shop for the lowest available price on standard items may not be realistic.

We believe that if beneficiaries are reimbursed on the basis of the 25th percentile they should be routinely informed about where they can acquire standard durable medical equipment items at or below these allowances.

CONCLUSIONS

Except for Connecticut, there were large geographical areas in the States reviewed with thousands of Medicare beneficiaries where standard items were not available at the lowest charge level. Although the assignment rate impacts more positively on the availability to beneficiaries for rentals than for purchases at the lowest charge level, there are not enough assignment rate data available to accurately determine the impact. In addition, there have been problems with developing, applying, and monitoring the provisions. Carriers have not had enough data to calculate 25th percentiles for purchases.

We believe that HCFA's emphasis on the pending implementation of section 16 of Public Law 95-142, which requires reimbursement based on the purchase of durable medical equipment whenever less costly than rental, and on developing additional screens to reduce costs can lead to lower assignment rates. Because suppliers bill a beneficiary directly for their total charge and generally expect payment for the difference between their actual charges and Medicare lowest charge reimbursements on nonassigned claims, lower assignment rates will have the effect of transferring more of the durable medical equipment costs to the beneficiary. Further, for suppliers who accept assignment on rentals but not on purchases, the application of the 25th percentile could defeat the purpose of section 16 of Public Law 95-142 by requiring the beneficiaries to pay a larger portion of the bills.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to:

--Discontinue applying the 25th percentile on purchases because (1) there are not enough data to compute it, (2) equipment is not widely and consistently available at the computed price, and (3) the limits tend to defeat the purpose of Public Law 95-142 which would require purchase if less costly than rental.

--Require carriers to compute data on assignments for items subject to the lowest charge levels to monitor the availability of such items.

--Inform beneficiaries, or their doctors, of where items can be acquired at or below the allowed amount or suppliers that usually accept assignments.

CHAPTER 3

COVERAGE AND REIMBURSEMENT POLICIES ARE INCONSISTENT AMONG HCFA REGIONS AND CARRIERS

The durable medical equipment, oxygen and oxygen equipment reimbursement, coverage, and utilization policies followed by carriers in the Atlanta region differed from those followed by carriers under the jurisdiction of the Boston, Kansas City, and San Francisco regions. Even among the carriers in the Atlanta region there were inconsistencies in the specific criteria that beneficiaries served by each carrier had to meet. Consequently, beneficiaries and suppliers (depending upon where they lived or were located) were subject to different reimbursement coverage and utilization criteria. While such criteria may be needed, they should be developed on a national basis and should be uniformly and consistently applied. Some carrier officials and medical equipment dealers in the Atlanta region questioned the appropriateness of the use of coverage and utilization screens in that region and whether any savings had been achieved.

The carriers in the Atlanta region also perform tests, which the carriers in other regions do not, to assess the "inherent reasonableness" of submitted charge data. The tests were not based on formal guidelines or criteria.

INITIATIVES OF THE HCFA ATLANTA REGION

In the spring of 1978, HCFA-Atlanta reviewed carriers' processing of claims for durable medical equipment and oxygen. These reviews showed that carriers generally accepted a physician's prescription as establishing medical necessity without question, and they did not apply utilization screens, consider other factors in developing reasonable charges, or subject reasonable charge calculations to a test of "inherent reasonableness."

The region addressed these issues by instructing its carriers to (1) clarify coverage of specific items of equipment including oxygen, (2) use detailed utilization screens, and (3) consider other factors besides actual submitted charges in developing reasonable charges. HCFA officials said that the carriers in the Atlanta region have also installed a common descriptor system which provides a uniform, precise procedural terminology for use in processing claims. According to HCFA, the system has been well received and used by the suppliers and allows them to prepare bills precisely and accurately describe items that they market and service.

COMPARISON OF COVERAGE AND UTILIZATION SCREENS USED BY CARRIERS IN ATLANTA AND OTHER HCFA REGIONS

The carriers in the Atlanta region under general guidelines provided by HCFA developed and implemented coverage and utilization screens for use in processing durable medical equipment claims, including oxygen and oxygen equipment. The screens being used relate primarily to oxygen and oxygen equipment, but also extend to such durable medical equipment as beds and wheelchairs. The screens include: (1) screens to limit oxygen payments to the least costly delivery method, (2) low volume screens to identify payments for oxygen equipment for beneficiaries who need oxygen only on a standby basis, (3) blood gas studies to test a patient's medical need for oxygen, (4) pulmonary function tests to check a patient's medical need for intermittent positive pressure breathing (IPPB) machine therapy, and (5) concurrent coverage screens to identify beneficiaries who are renting two types of equipment that perform the same function. The nature of these screens and their use among carriers in the Atlanta and other HCFA regions is discussed below.

Least costly delivery method screen

The least costly delivery method screen is used to set the maximum monthly payments Medicare will make to or on behalf of beneficiaries using oxygen. This screen, which is also called a high volume oxygen screen, limits reimbursement for oxygen and oxygen equipment to the rate allowed for oxygen concentrators. Atlanta was the only HCFA region we visited that used this screen.

Atlanta implemented the screen in March 1979 at which time the regional office considered concentrators were available and their use fairly widespread. Concentrators, which manufacture oxygen-enriched air in the home, are very economical for patients who require continuous or near-continuous oxygen. As a result, HCFA-Atlanta directed its carriers to identify gaseous and liquid oxygen patients whose usage exceeded the levels at which concentrators became cost effective as compared to the traditional delivery systems. The reimbursement for these patients is reduced to the allowance for the concentrator.

In addition to limiting the payments for oxygen to a maximum rate, the least costly delivery method screen also represents a minimum oxygen usage level that a patient must meet to qualify for a concentrator. If a patient has a concentrator, for example, but uses less than the amount of oxygen at which these devices become cost effective, the claim would be paid based on the least costly delivery method which would be either gaseous or liquid oxygen.

The high volume oxygen levels used to screen oxygen claims generally vary from State to State in the Atlanta region depending

on the allowed reimbursement rates for (1) oxygen concentrators and (2) gaseous and liquid oxygen with associated delivery equipment. The screen, therefore, is determined by computing a break-even point to establish the levels where an oxygen concentrator becomes cost effective.

Carrier representatives in the Atlanta region told us that the least costly delivery method screen was generally applied to all oxygen claims showing a high volume usage. However, there were certain circumstances where this screen would not be applied, such as where the (1) beneficiary's home does not have electricity or cannot physically accommodate an oxygen concentrator and (2) beneficiary requires a higher percentage of pure oxygen than a concentrator can provide, or is ambulatory and has to be away from the stationary oxygen supply.

Except for these cases, all gaseous or liquid oxygen claims which exceed the high volume oxygen use parameters that are automatically reduced to the rental allowance for oxygen concentrators.

Low volume oxygen screens

The low volume oxygen screens are designed to identify patients who use oxygen on what is considered to be a precautionary or standby basis. The Medicare program's coverage of oxygen does not extend to oxygen used on a standby or precautionary basis. Since Medicare has no national minimum oxygen requirement, the Atlanta region established a minimum monthly oxygen usage requirement that beneficiaries must exceed to qualify for oxygen coverage. Connecticut General was the only carrier of the five visited outside the Atlanta region that had implemented a low volume screen.

At the time of our visits, an oxygen patient in Georgia and South Carolina must use at least 488 cubic feet of gaseous oxygen or 40 pounds of liquid oxygen each month to qualify for reimbursement of the oxygen and the oxygen equipment. If a patient's usage falls below this level, the claim for both the oxygen and the oxygen equipment would be denied. The Florida carrier, however, does not have a minimum oxygen usage requirement to identify standby oxygen use. Instead, the carrier checks claims for oxygen equipment against prior data to ensure that oxygen is being used by the beneficiary. If a beneficiary is renting oxygen equipment, but no oxygen purchases are found during the previous 2-month period, the claim for the oxygen equipment would be denied.

Connecticut General and Alabama Blue Shield currently use a screen of 244 cubic feet of oxygen per month, but only as an indication of possible standby oxygen. In such cases, each carrier requests further documentation of medical necessity. Between November 29, 1979, and March 28, 1980, Alabama Blue Cross/Blue Shield denied all oxygen claims for less than 244 cubic feet of gaseous

oxygen or 50 pounds of liquid oxygen per month. As of March 28, 1980, the carrier changed its policy of automatically denying payment on these claims. These claims are now referred to a medical consultant for review.

Connecticut General was instructed by a Boston HCFA official that the use of less than 244 cubic feet of oxygen per month should not be the only basis for coverage or denial. This differs from the policies being followed by some carriers in the Atlanta region which automatically deny coverage when usage is below 488 cubic feet per month.

Blood gas study screen

The blood gas study measures the parts of oxygen in the patient's blood, and therefore, it provides an indication of a patient's need for oxygen. The results of these tests are used by carriers in the Atlanta region and Connecticut General as guidelines in determining Medicare's coverage for oxygen claims. The test is a covered expense under the Medicare program.

Connecticut General along with the carriers in Georgia and South Carolina have established specific values for use in determining coverage for oxygen claims. However, none of these carriers use the study results as an absolute basis for denying or allowing oxygen claims. The carriers in Alabama and Florida, however, only use the study results when additional information is needed on a particular claim or when a supplier or beneficiary requests a review of a previously denied claim.

In 1978, Connecticut General implemented the blood gas study screen. Initially the carrier, except in certain cases, such as heart disease, required the study before coverage of oxygen would be approved. Presently, however, Connecticut General has accepted a narrative explanation of medical necessity from a physician in lieu of the study. Carrier representatives in Georgia and South Carolina told us that the results of blood gas studies are used primarily to identify claims that should be reviewed by the medical staff for coverage determinations.

Pulmonary function test screens

The pulmonary function test, which measures a patient's vital lung capacity, may be used to determine whether or not Medicare will cover an IPPB machine. The need for the test and achievement of specific test values required for IPPB coverage varied among the carriers reviewed. The test is a covered expense under the Medicare program.

The carriers in Georgia, Florida, and South Carolina have implemented specific criteria that are used in determining coverage for IPPB machine therapy. Although the values used vary, each requires that a patient's vital lung capacity be below a certain percentage of the predicted value based on the patient's age, height, and weight. Also, the Georgia and Florida carriers require that a patient show a certain amount of improvement in vital lung capacity following IPPB treatment to continue to qualify for coverage.

Although the South Carolina carrier has established specific requirements for IPPB coverage, carrier officials told us that these criteria are not necessarily used as a basis for claim denials. Instead, the carrier's medical staff used the test results as an indication of the need for IPPB therapy when a question of medical necessity arises. According to carrier representatives, questions of medical necessity could arise concerning the type of disease for which the IPPB therapy is prescribed or the type of therapy program to be followed.

The carrier in Alabama, however, does not have a specific pulmonary function test value that is used in determining coverage for IPPB machines. Instead, the pulmonary function tests are reviewed by the carrier's medical staff in making coverage decisions in this State.

None of the five carriers we visited outside of the Atlanta region used the test as a basis for approval of the IPPB. These carriers rely on a beneficiary's physician's judgment as to whether the IPPB machine is needed.

Concurrent coverage screens

The concurrent coverage screens developed and implemented in the Atlanta region are used to identify equipment combinations that are duplicative or have conflicting medical necessity requirements that would preclude their concurrent use by beneficiaries.

The rationale behind the screens is that use of certain equipment conflicts with or duplicates other items. For example, the concurrent coverage screens show that a beneficiary using trapeze bars would not simultaneously qualify for a patient lift. A trapeze bar assists the patient in changing body positions or exercising in bed. A patient lift is designed to remove a patient from bed. The rationale supporting the mutual exclusion of these items is that, because both items serve the same purpose, they would not both be covered at the same time.

The only carriers we contacted that fully used the concurrent coverage screens were in the Atlanta region. Even among these carriers the degree of implementation varied. The Florida carrier,

for example, did not implement the screens that applied to some low cost items because the benefits expected to be derived from the screens were less than the cost of implementation. In addition, the Georgia carrier expanded the concurrent coverage screen list to include items that had not originally been identified by HCFA.

SUPPLIER AND CARRIER COMMENTS ON VALIDITY OF SCREENS

Some durable medical equipment suppliers and carrier medical staff contacted in the Atlanta region questioned how valid the screens were for denying coverage. The following highlights the comments we received on each screen.

Low volume oxygen - Some suppliers and carrier medical personnel considered, contrary to HCFA-Atlanta, that beneficiaries could receive a medically therapeutic benefit from the low volume oxygen screen requirement of 488 cubic feet of gas or 40 pounds of liquid.

Blood gas study - Officials at one carrier criticized the test noting that the results are only valid for 30 days or less. Furthermore, the study results could vary depending on the type of disease, patient's condition, and factors present when the test was taken.

Pulmonary function test for IPPB - Some suppliers questioned using a relative pulmonary function test value to make coverage determinations because of the potential variance in results from patient to patient. A carrier medical representative told us that he tried to consider such factors in making coverage decisions, but they could not always be determined from available information.

High volume oxygen - Some suppliers told us that, although concentrators are more economical for high oxygen users than more conventional oxygen systems, they did not purchase as many of them as might be needed at any given point because of the equipment's high cost. Furthermore, suppliers stated that concentrators, being a relatively new device, may not be available in some places--especially in rural areas.

Concurrent coverage - The current use of these screens was questioned by supplier representatives. Suppliers told us, for example, that the screen preventing concurrent coverage of trapeze bars and patient lifts was not valid. They pointed out that a patient may be able to change his or her body position while in bed by using the bars and still need assistance from another person--and therefore, a lift--to get in and out of bed. Suppliers stated, therefore, that these items do not necessarily serve the same purpose.

A carrier medical staff representative stated that the concurrent coverage screens, as now defined, may not have suffient flexibility to cover situations that may normally be expected in home therapy programs. Because of this, certain aspects of these screens may require revision.

On December 2, 1980, HCFA officials told us that concurrent coverage screens will be changed as needed. One such change, involving patient lift/trapeze bars, had already been made.

COVERAGE AND UTILIZATION SCREENS NEEDED, BUT THE IMPLEMENTATION OF THEM IN THE ATLANTA REGION IS QUESTIONABLE

Coverage and utilization screens assist the carriers in determining the medical need for prescribed equipment and oxygen. They provide the carriers with a rational basis from which they can make determinations for reimbursements. Without screens, carriers usually accept the physician's prescription as establishing the medical need for prescribed durable medical equipment. However, the carriers we visited, except in the Atlanta region, did not extensively use screens.

Our analysis of a sample of claims for 384 beneficiaries at four carriers outside the Atlanta region 1/ identified 46 instances where the application of the low volume oxygen screen might have avoided some unnecessary payments. For example:

--In Missouri, a beneficiary rented a regulator for almost 2 years for which Medicare paid $220, but purchased no oxygen. When General American personnel questioned this, they were informed by a relative of the beneficiary that a social worker suggested keeping the regulator around the house because it gave the beneficiary a secure feeling.

--In Missouri, a beneficiary rented an oxygen regulator for $22 a month, yet for 5 months there was no oxygen purchased. General American's medical consultant still considered the equipment necessary even though the beneficiary had not used much oxygen.

--A beneficiary serviced by Vermont/New Hamphsire Medical Service had not used the oxygen equipment in her home for over a year after she was discharged from the hospital. During this time Medicare paid about $200. The beneficiary had requested that the equipment be returned, but the

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1/New Hampshire/Vermont Medical Service, Connecticut General, Kansas City Blue Shield, and General American Life Insurance Company.

supplier who periodically checked the oxygen supply did not remove the equipment. After we brought this case to the attention of the carrier, the rental payments were stopped.

While HCFA-Atlanta and its carriers implemented the screens, the use of the screens varied as to how they were applied and to what criteria were used. The screens are summarized in the table below.

Oxygen/IPPB Therapy Screens

	Georgia	Alabama	South Carolina	Florida
Least costly delivery method or high volume oxygen:				
Gaseous (cubic feet)	2,450	2,440	3,660	2,462
Liquid (pounds)	208	200	305	207
Low volume oxygen:				
Gaseous (cubic feet)	488	244	488	Alternate screen implemented
Liquid (pounds)	40	50	40	
Arterial blood gas values for oxygen coverage	55	Required only when more information is needed for medical coverage determination	60	Required only when suppliers or beneficiaries request a review of a denied claim
Pulmonary function test values for IPPB coverage:				
Percent of predicted value	60	a/no set value	50	65

a/Used by carrier medical staff for coverage determination.

The variances in the screens shown above resulted primarily from carriers using inputs from different medical sources to set specific criteria. Although some variances might be expected, the medical criteria used should be consistent. As currently implemented, however, the screens being used in the Atlanta region have essentially resulted in differences in program coverage.

HCFA officials agreed that coverage and utilization screens need to be implemented very carefully to make sure they reflect accepted medical practice. They also stated that such screens should be used only as screening devices to distinguish claims that can be allowed routinely from those that require more development to resolve questions of medical necessity.

TESTS OF ESTABLISHED REASONABLE CHARGES FOR "INHERENT REASONABLENESS"

All the carriers in the Atlanta region used "inherent reasonableness" tests to assess the validity of computed durable medical equipment prevailing reasonable charge allowances. 1/ They use it to an extent not used by carriers visited in other HCFA regions.

Although the use of the other factors is provided for in the Medicare regulations, the regulations do not state what other factors should be considered. The Medicare Manual does provide some guidance. It states that reasonable charges made in the competitive marketplace (a marketplace in which Medicare and Medicaid are not the sole or major source of payment) should be considered.

HCFA-Atlanta officials stated that they had not developed any formal guidelines or criteria for the carriers to use in assessing the "inherent reasonableness" of reasonable charges established on submitted charge data. These officials told us that the carriers compared the percentage increase in rates from one period to another as an indication of reasonableness. HFCA-Atlanta has not established a percentage which would be considered unreasonable, but has stated, for example, that a 40-percent increase in an allowance from one period to another would indicate that the new rate should be reviewed. Therefore, in such cases, other data would be used to determine the validity of the computed data and, if necessary, to establish the allowance for the item.

Other data used by carriers in these assessments include manufacturers' suggested retail prices, economic indices, or rates computed by other carriers within the region. The primary source of data used in these assessments, however, is the suggested retail price lists from major manufacturers of durable medical equipment.

Current data not used in inherent reasonableness tests

The four carriers visited in the Atlanta region used 1-year-old price lists when performing their tests for inherent reasonableness. Current price lists are not used because the charge data being compared are at least 6 to 18 months old. Carriers revise their reasonable charge calculations once a year and the revised rates are effective during July. The revised rates are based on charge data contained in claims processed during the

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1/Except for items subject to the lowest charge allowance (see ch. 2), the prevailing charge limits are usually set at the 75th percentile of suppliers' customary charges in a locality.

preceding calendar year. 1/ Price lists are used primarily to establish reasonable charges for purchases.

Therefore, to provide for a comparable base, 1-year-old price lists are used. HCFA officials stated that the use of 1-year-old price lists might be appropriate since the charge data are derived from a prior period. We disagree. Beneficiaries cannot normally be expected to purchase equipment in 1980 at amounts established by Medicare based on 1979 price lists.

Lack of criteria may lead to unreasonable adjustments

No formal criteria have been developed by HCFA-Atlanta, as to when and how tests for inherent reasonableness should be performed. Some reductions made by carriers for inherent reasonableness appear restrictive. For example, HCFA asked South Carolina Blue Shield to reevaluate the January 1980 computed 25th percentile rental allowances for standard hospital beds and wheelchairs because they represented increases of about 15 and 20 percent, respectively, over a 6-month period. On this basis, the carrier decreased the allowances for these items to a rate that was below the computed 25th percentile and allowed increases of 4 and 10 percent, respectively. However, allowances for these items had not increased since July 1978. Therefore, the 4- and 10-percent increases were the first in 18 months.

In another case, HCFA-Atlanta requested Florida Blue Shield to reduce the computed rental rate of $210 for an oxygen concentrator even though the carrier considered the rate to be appropriate. HCFA's rationale was that additional time was required to allow comparison of the rate with data from other States. Therefore, the carrier at HCFA's request maintained in the July 1979 update the same allowance, $190, it had established in July 1978. A carrier representative told us that the reduced allowance remained in effect until July 1980.

Inherent reasonable tests generally not used by carriers outside of Atlanta region

The five carriers reviewed outside of the Atlanta region generally do not test calculated prevailing charges for inherent reasonableness and do not compare percentage increases from one period to the next. Price lists and regional comparability are occasionally used, but only when limited or no charge data exist (e.g., a new item of equipment). One carrier official stated that

1/This methodology differs from that used in establishing the lowest charge levels as discussed in chapter 2.

it does not review established reasonable charges for inherent reasonableness because HCFA has not issued criteria for what is reasonable.

COST BENEFITS OF SCREENS AND INHERENT REASONABLENESS ARE DIFFICULT TO MEASURE

Cost benefits from utilization and coverage screens for durable medical equipment are difficult to measure. Only one carrier--Blue Shield of Florida--has been able to develop an estimate of savings from using these screens. During 1979, the carrier denied a total of $267,814 for the rental of oxygen equipment. These claims were denied using the low volume oxygen screen, i.e., carrier automatically denies rental of all oxygen delivery equipment if there is no purchase of oxygen within a specific amount of time (60 days back from the "from" date of service and 30 days forward from the "to" date of service). The carrier did not estimate how much it cost to establish and maintain this screen.

HFCA-Atlanta has estimated that the use of tests for inherent reasonableness will save the Medicare program at least $5.6 million during the January through December 1979 period. This estimate is overstated because it does not consider (1) the costs incurred by the carriers to perform the tests for inherent reasonableness and (2) that some claims are paid on the basis of actual or customary charges when such charges are lower than the inherently reasonable established amount.

CONCLUSIONS

The coverage and utilization screens used by HCFA-Atlanta differ from those used in the Boston, San Francisco, and Kansas City regions. Beneficiaries in the Atlanta region, for example, must meet certain criteria that beneficiaries in other parts of the country do not have to meet for items to be covered by Medicare. Even within the Atlanta region beneficiaries have to meet differing requirements depending upon which State they live in.

Although variations among Medicare carriers in reimbursement coverage and medical policy matters is neither unusual nor necessarily inappropriate, the degree to which such variations are imposed by the administrative agency in one region of the country is a matter of concern. It seems to us that if the screens imposed by HCFA-Atlanta are valid, then they should also be imposed elsewhere.

The use of guidelines to identify unnecessary or unreasonable Medicare claims is appropriate; however, the validity and cost effectiveness of the screens currently being used in the Atlanta region is uncertain. For example, there are indications that the

current screens (1) are questionable from a medical standpoint, (2) require data that are useful for a limited time, or (3) do not adequately address the availability of equipment to beneficiaries.

Although not inconsistent with Medicare regulations, tests for inherent reasonableness used by HCFA-Atlanta in establishing equipment allowances were not governed by any specific criteria or guidelines. In addition, the tests were restrictive because they limited allowances to levels that beneficiaries could not normally be expected to find in the current marketplace. These tests were also generally not used by carriers outside the Atlanta region.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to:

--Insure that Medicare policies, practices, and coverage and utilization screens required by HCFA are consistently applied in all regions.

--Determine, to the extent practicable, the cost effectiveness of coverage and utilization screens before or during their implementation.

CHAPTER 4

OTHER ISSUES IN THE ATLANTA REGION

HCFA-Atlanta and the carriers have reacted positively to suppliers' complaints regarding their being informed of policy and program changes. The lead time for notifying suppliers of policy and program changes was extended in early 1980 in the Atlanta region, but according to the suppliers it still may not be adequate.

Postpayment reviews conducted by carriers in the Atlanta region conform to the requirements in the Medicare Manual, which are applicable to all carriers, and the reviews of delivery charges were based on reasonable procedures and criteria. However, some suppliers in the region told us that reviews of claims up to 4 years old are not reasonable and that these reviews are unfair because the claims were originally accepted and paid by Medicare.

POLICY CHANGE NOTIFICATION PROCEDURES

Carriers should give suppliers adequate notice and enough time to adjust to policy changes. Supplier representatives in the Atlanta region told us that the time given was not sufficient for them to obtain information on medical necessity and provide other information required by Medicare policies and regulations. Suppliers also complained to the Senate Health Subcommittee staff that they became aware of new requirements only after claims had been denied because the new requirements had not been met.

HCFA-Atlanta has acted on supplier concerns. A March 1980 HCFA regional Intermediary Letter instructed carriers to develop a well defined process to inform suppliers of significant changes and to notify suppliers well in advance (generally 45 days) of any significant changes.

Suppliers told us that after these instructions, the carriers in the region were giving from 30 to 45 days notice of policy changes or new claim information requirements, but that this still may not be adequate in many cases. They pointed out, for example, that some of Medicare's changes required having doctors provide additional medical necessity information on the patient's need for equipment and therapy or changing the billing data on claims. In such cases, suppliers stated that they needed from 60 to 90 days to obtain the additional information or to change billing procedures.

In addition, a representative from one carrier stated that it generally takes about 90 to 120 days to implement major changes in the program. Although HCFA may give the carriers 30 to 60 days notice before the effective date of changes, carriers can delay

the effective dates to allow time to make required adjustments. For example, South Carolina Blue Shield delayed the implementation of the lowest charge level provision from February to July 1979. Suppliers, however, must react to new requirements and reimbursement policies within the lead times provided by carriers and HCFA.

HCFA officials believe 45 days notice is adequate in nearly every case. However, if a particular change is determined to be unusual, they stated additional lead time would be considered.

Except to note that HCFA-Atlanta did react positively to suppliers' complaints in this area, we have no basis for judging what is an adequate lead time.

POSTPAYMENT AUDITS CONSISTENT WITH PROGRAM INSTRUCTION

Postpayment audits, covered by section 7080.1 of the Medicare Part B Manual, were conducted by all four carriers reviewed in the Atlanta region. The manual allows carriers to audit a claim up to 4 years after the claim is paid. In conducting these audits, carriers look at a variety of claim information.

Audits may be based on complaints by beneficiaries and suppliers or on referrals from their own claim processors. The audits also include all suppliers of durable medical equipment whose reimbursement exceeds $100,000 in a year. After identifying these suppliers, a number of their claims are reviewed. If any problems, such as overutilization, are suspected, the beneficiary's attending physician is sent a letter requesting medical information justifying the claim. The supplier is also notified by letter of the review.

Suppliers question reasonableness of audits

The suppliers we contacted in the Atlanta region were concerned about the practices and procedures followed by carriers in conducting postpayment audits. Their primary concern was the lack of reasonable time limitations for conducting these audits. One supplier told us, for example, that carriers would often request repayment of funds paid 2 or 3 years before. Due to this practice, suppliers could not be certain that equipment and services provided were considered valid by Medicare, especially when the claims had initially been accepted and paid. Suppliers also told us that in many cases they had no recourse for collecting the amounts questioned if the beneficiaries had died or could not pay for the services.

While the suppliers' concerns may be valid, in as much as such postpayment audits were consistent with program instructions, we did not conclude that suppliers in the Atlanta region were being

subjected to different rules than suppliers elsewhere, as was the case regarding the coverage and reimbursement issues discussed in chapter 3.

DELIVERY CHARGE AUDITS WERE JUSTIFIED

In January 1979, HCFA-Atlanta directed carriers to no longer reimburse suppliers for mileage incurred during delivery of durable medical equipment. Before this, suppliers were reimbursed for normal setup and delivery charges. HCFA's Atlanta Office of Program Integrity directed its carriers to conduct a postpayment audit of suppliers who received more than $25,000 from Medicare during 1978 and also billed for delivery on a mileage basis. The audit was initiated when the Office learned that some suppliers who charged for delivery on a mileage basis were billing for mileage not incurred.

Scope of carriers' audits

Initially, the Office of Program Integrity directed the carriers in South Carolina, Georgia, Tennessee, Mississippi, and Florida to audit suppliers who billed for delivery on mileage. Mississippi and Florida were eliminated from the audit. In Florida, it was determined that the carriers did not pay for delivery on a mileage basis. In Mississippi, no erroneous billing practices were found. The audit in Tennessee was still being conducted at the time of our visit, and therefore, no results were available.

The procedures used in determining the amount of overpayments made to suppliers were developed by the Office of Program Integrity. These procedures required that the carriers audit all suppliers who received more than $25,000 from Medicare in 1978 to determine which of these suppliers billed separately for deliveries. Once suppliers were identified, the number and location of deliveries for a given day were plotted on maps to determine the total round trip mileage to a given area from the supplier's place of business. The mileage charges thus determined were then compared to the suppliers' billings for these same deliveries to establish the amount of overpayments, if any.

Results of audits

Results from South Carolina and Georgia show that suppliers had overcharged the Medicare program about $112,000 in delivery fees. The carriers determined that some suppliers were billing multiple round trips to deliver equipment to beneficiaries in a locality even though only one round trip was made. Suppliers would deliver equipment to beneficiaries in the same vicinity. Rather than billing delivery on the basis of mileage traveled, each beneficiary would be billed for the total mileage as if no other

deliveries were made. The result of this practice was that suppliers were charging the Medicare program and beneficiaries for more mileage than had actually been incurred. Although the Medicare regulations in effect at that time allowed for separate payments for deliveries, Office of Program Integrity officials told us that the policy was never intended to allow payments for mileage not incurred.

Some suppliers contacted believed that the delivery charge audit was unwarranted. Suppliers told us they had normally billed the total mileage for each item delivered--as described above--even though several deliveries may have been made in the same area on the same trip. One supplier told us that he had been billed in this manner based on the verbal guidance provided by the Medicare carrier in his State.

The procedures used by HCFA-Atlanta in conducting the delivery charge audit appear to be appropriate. The guidelines were designed to identify only the charges for mileage not actually incurred, and the carriers conducting the audit did not question delivery charges that were considered appropriately billed. Therefore, on this basis the procedures used in the delivery charge audit were reasonable.

SUMMARY

HCFA-Atlanta has directed its carriers to improve their notification procedures to suppliers regarding policy and program changes. Improvements have been made; however, suppliers told us that the lead time still is not adequate for them to respond to all changes. While carriers can request a delay from HCFA in implementing changes, suppliers do not have the same opportunity.

HCFA-Atlanta and its carriers adhered to the Medicare Manual in conducting postpayment reviews. However, suppliers believe that it is unfair to review claims up to 4 years old. While postpayment reviews are desirable as indicated by the review of delivery charges, a 4-year-old time frame may require further study. HCFA officials stated that they would review their policies to determine whether any changes are warranted.

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